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MENTAL HEALTH, MEANING OF MENTAL HEALTH [ADDENDUM]

In contemporary scientific, medical, and philosophical terrains, the concept of mental health continues to be discussed in relation to various approaches to mental illness. The early twentieth century featured two dominant approaches to mental illness, interpretive psychiatry (e.g., Freudian psychoanalysis) and empirical psychiatry. Psychoanalysts, including Sigmund Freud (1856–1939) and Carl Jung (1875–1961), developed explanations for mental illness in relation to general functioning of human mental life. The person as a whole, including his or her relation to the past and the future and to the social and physical environments, was the target of inquiry.

For their part, empirical psychiatrists investigated symptoms and signs of mental illness, thereby grounding the notion of mental illness on readily measurable phenomena and isolating them from the whole person. Emil Kraepelin (1906) recorded mental illness in a large patient group over many years and grouped them according to their shared syndromes. He divided mental disorders into manic-depressive psychosis (bipolar disorder) and dementia praecox (schizophrenia). While Freudian psychoanalysts attribute mental disorders principally to early childhood experiences and psychic forces, Kraepelin believed such disorders could be explained only by the controlled experimental methods of neuroscience and genetics and the empirical techniques of biological medicine. His classification system has influenced contemporary psychiatric taxonomy. Beginning with the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) (American Psychiatric Association 1980), published in 1980, psychiatrists followed Kraepelin's approach.

The German psychiatrist and philosopher Karl Jaspers (1883–1969) reconciles the person-based approach of interpretive psychiatry with empirical psychiatry by arguing that mental disorders must be explained through the observation of regularity and patterns in an individual's behavior. This approach must be supplemented, however, with an understanding of that individual's "meaning-relations" (Jaspers 1997 [1913]).

Since the second half of the twentieth century, debates on mental illness have swirled around the question of whether the concept of mental illness is marked by fundamental, evaluation-independent facts about the human body or constituted by normative judgments. According to "objectivists," there are facts about the human biology (e.g., brain mechanisms) on which the notion of mental illness is founded (Kitcher 1997). Once scientists have a clear picture of such facts, drawing the line between mental illness and mental health will no longer be challenging. Meanwhile "constructivists" argue that judgments about what constitutes mental illness are necessarily normative and that mental illness is an intrinsically value-laden concept.

One expression of this controversy is the debate between antipsychiatrists and propsychiatrists (Fulford, Thornton, and Graham 2006). Known as the founder of the antipsychiatry movement, Thomas S. Szasz (1960) argues that mental illness is a myth; it is not a genuine illness in the sense that bodily illness is. For Szasz, physical illness deviates from scientific-factual norms, but what is construed as mental illnesses deviates from "psychological, ethical, and legal" norms. As a constructivist about mental illness, he argues that they are just "problems of living." Other antipsychiatrists include T. J. Scheff (1974), according to whom the features of mental illness are the individual's response to being labeled deviant, and R. D. Laing (1960), who emphasizes the meaning in the apparently irrational and meaningless symptoms of mental illness. The greatest contribution of antipsychiatry to the literature is the discussion of the place of values in descriptions of mental health and illness (Fulford, Thornton, and Graham 2006).

Antipsychiatrists are challenged by propsychiatrists. According to R. E. Kendell (1975), some conditions perceived as mental illnesses are in fact very similar to physical illnesses. Kendell defines mental illness as a

biological disadvantage. Christopher Boorse is also an objectivist, defining mental health as the absence of disease, where disease is a type of "internal state which impairs health, i.e. reduces one or more functional abilities below typical efficiency" (Boorse 1975, 55). It is important to note that Boorse distinguishes "illness" from "disease"; the former is a normative notion in that it needs to "incapacitate" the individual, whereas the notion of disease is value free.

K. W. M. Fulford (1989) identifies the source of the controversy between these two positions as the assumption that the concept of physical illness is conceptually simple and value-free. This assumption motivates antipsychiatrists misguidedly to compare mental illness with physical illness and motivates propsychiatrists to argue that mental illness, like physical illness, is fact driven and value-free. Fulford aims to move beyond the controversy between objectivism and constructivism by announcing that the concepts of both physical and mental illness are value laden. What is different and more complex in the context of mental illness is that human values are more diverse when they involve emotion, volition, belief, and desire than are attributions of norms in the context of physical illness.

Another important issue in contemporary conceptions of mental health is contemporary psychiatric taxonomies. The classification of mental disorders is fundamental to directing scientific inquiry toward the nature and treatment of psychopathology, as it provides the conceptual schema with which to think about mental disorder, facilitates the development of experimental paradigms to test hypotheses about their etiology, and develops effective treatment strategies in clinical settings.

Two dominant classification systems are in use in the early twenty-first century: chapter 5 of the *ICD-10: International Classification of Diseases* produced by the World Health Organization (1989) and the *Diagnostic and Statistical Manual of Mental Disorders: DSM-V* by the American Psychiatric Association (2013). While the World Health Organization (1948, 100) defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, no definition of mental health underpins the editions of the *Diagnostic and Statistical Manual of Mental Disorders*. Rather, mental disorder is defined as "a syndrome characterized by clinically significant disturbance in individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association 2013, 20). Inspired by the Kraepelian classificatory schema, both list categories of mental disorders according to symptoms and signs. Their codes for mental disorders deliberately converge to ensure reliable diagnosis across clinical and scientific settings. The DSM and the ICD are used for research, treatment, forensics, insurance, and various other administrative purposes, thereby setting the stage for the scientific, medical, and folk understandings of mental health and illness.

One concern about these systems is the value ladenness of disorder categories despite commitment otherwise (Sadler 2005; Tekin forthcoming b). An often-cited example is the classification of homosexuality as a type of mental disorder in the DSM-III and its removal from the DSM as a result of strong lobbying efforts by gay rights activists. The value ladenness of disorders is still debated in the context of certain categories, such as personality disorders.

Another concern is whether the diagnostic schema that defines mental disorders operationally can guide research and treatment and serve forensic and administrative purposes. These concerns have been compounded by the publication of the fifth edition of the DSM (American Psychiatric Association 2013). For example, in the DSM-5 the bereavement exclusion has been removed from the diagnostic criteria for major depressive disorder, stirring significant debate in the literature about overmedicalization (Tekin forthcoming a). Finally, since the mid-1990s the rejuvenated field of philosophy of psychiatry has continued to be populated by scientific and value-related concerns over the descriptions of mental health and mental illness.

SEE ALSO *Children: III. Health Care and Research Issues; Coercion; Confidentiality; Informed Consent: VI. Issues of Consent in Mental Health Care; Institutionalization and Deinstitutionalization; Life, Quality of; Mental Health Services; Mental Health Therapies; Mental Illness; Mentally Disabled and Mentally Ill Persons; Patients' Rights: II. Mental Patients' Rights; Psychiatry, Abuses of*

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MENTAL HEALTH SERVICES

This entry consists of the following:

I. SETTINGS AND PROGRAMS

Since the mid-1950s, fundamental transformations have taken place in the size, location, diversity, funding, and attitudes toward mental health services in the United States, changing the organized response to the identification and treatment of mental health problems. These changes have altered the central policy and ethical questions that arise in the mental health system as a whole. When involuntary commitments to custodial mental hospitals dominated the system, the central issues involved inappropriate social control. In the diversified system based on community care and treatment that has evolved, the most pressing issues include how to fund and deliver services to the most seriously ill persons, allocate services to meet a potentially huge demand, and improve service delivery outside the traditional system of mental health care.

EVOLUTION OF MENTAL HEALTH SERVICES

Until the mid-1960s, two separate systems dominated mental health services: public mental institutions that treated a large population of inpatients and a smaller private sector that provided most outpatient psychotherapy. Large, impersonal, custodial facilities dominated the inpatient sector and housed poor, isolated, severely mentally ill persons (often elderly) for long periods of time (Grob 1991). Most residents lacked family ties or were committed as a last resort by their families. The flaws of these institutions are well known: huge size, overcrowding, geographic isolation, involuntary confinement, depersonalization, coercion, and custodial emphasis (Goffman 1961). Nevertheless, they provided the most seriously ill persons an integrated range of services—housing, food, symptom management, respite from stressful community conditions, medical treatment, and a locus for social interaction—in one centralized location. Alongside the core of state mental hospitals, a smaller outpatient sector dominated by private psychiatrists practicing analytic psychotherapy treated clients who could afford those services (Hale 1995).

The mental health system early in the twenty-first century was much different. Deinstitutionalization (i.e., the process of replacing long-term psychiatric hospitalization with community-based care) revolutionized mental health services beginning in the 1950s. The average number of residents in state and county mental hospitals declined from a peak of 550,000 in 1955 to 370,000 in 1969, and about 100,000 by 2004 (SAMHSA 2010; Torrey et al. 2010). Taking into account a growing general population, the number of psychiatric hospital beds in the United States fell from one bed per 300 people in 1955 to one bed per 3,000 people in 2004 (Torrey et al. 2010). Typical patients in state hospitals have also changed: from the elderly to the young; from long-term to short-term patients; and from persons with deteriorating and untreatable diseases of the brain to ones suffering from concurrent substance abuse disorders.

As state mental hospitals became institutions of last resort for the most intractable patients, alternative forms of inpatient care grew substantially. Less than 10 percent of admissions to twenty-four-hour care facilities occurred in state and county mental hospitals in 2004, a four-fold decline since 1969 (SAMHSA 2010). Most inpatient psychiatric services now take place in general hospitals,